Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

Respondent Name

SEABRIGHT INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0665-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthTrust performed 20 sessions of a multi-disciplinary chronic pain management program and the carrier has remitted on 19 of those 20 claims. However, on one check remittance, two specific dates of service were listed as if both were being paid on (5-16-2011 and 5-20-2011). However, attached to that check was the Explanation of Benefits and only the date of service 5-20-2011 was noted on it and that reflected the exact amount of the check. Therefore a reconsideration was sent in on August 16, 2011, and was mailed certified return receipt requested."

Amount in Dispute: $1560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2011	Chronic Pain Management – CPT code 97799-CP (8 hours)	$1560.00	$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 20, 2011
   - 598-The reimbursement for this procedure has been calculated according to the guidelines for a program that is not CARF accredited.
   - 790-001-This service was allowed based on case management review #.

Issues

1. Did the respondent support payment was made in accordance with state guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the chronic pain management service based upon reason codes "598-The reimbursement for this procedure has been calculated according to the guidelines for a program that is not CARF accredited"; and "790-001-This service was allowed based on case management review #".

   The requestor states in the position summary that "HealthTrust performed 20 sessions of a multi-disciplinary chronic pain management program and the carrier has remitted on 19 of those 20 claims. However, on one check remittance, two specific dates of service were listed as if both were being paid on (5-16-2011 and 5-20-2011). However, attached to that check was the Explanation of Benefits and only the date of service 5-20-2011 was noted on it and that reflected the exact amount of the check."

   The Division finds that the submitted EOB supports that only May 20, 2011 was paid. Therefore, date of service May 16, 2011 remains unpaid and is the basis of this dispute. The disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   >
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP for eight (8) units. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the eight hours billed is $800.00. The respondent paid $0.00. The difference between the MAR and amount paid is $800.00. This amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		4/25/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.